

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Laconia Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 175 Blueberry Lane Laconia, NH 03246	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49819</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 3 of 23 residents reviewed for MDS in a final sample of 23 residents (Resident Identifiers are #40, #45, and #112).</p> <p>Findings include:</p> <p>Resident #45</p> <p>Observation on 5/29/24 at approximately 10:00 a.m. revealed Resident #45 in bed with a tracheotomy and ventilator in place.</p> <p>Review on 5/31/24 of Resident #45 Significant Change MDS, with an Assessment Reference Date (ARD) of 3/18/24, revealed O0110F1B not selected for an invasive ventilator during the 14 day look back period (3/4/24 through 3/18/24).</p> <p>Review on 5/31/24 of Resident #45's provider orders revealed an order for ventilator settings during the 14 day look back period.</p> <p>Interview on 5/31/24 at approximately 10:20 a.m. with Staff C (Reimbursement Coordinator) confirmed the above findings.</p> <p>37488</p> <p>Resident #40</p> <p>Review on 5/30/24 of Resident #40's MDS with an ARD of 4/30/24, section P0100- Restraints and Alarms revealed that the section Used in Bed; A. Bed rail was coded with a #2, indicating it was used daily.</p> <p>Observation on 5/30/24 at approximately 10:30 a.m. of Resident #40's bed revealed a bed rail on the side of the bed that was against the wall.</p> <p>Review on 5/30/24 of Resident #40's Bed Rail Evaluation, dated 3/2/24, revealed that Resident #40 utilizes two 1/4 upper rails on the bed for mobility and transfers.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/31/24 at 8:30 a.m. with Staff C confirmed the above findings. Staff C further confirmed that Resident #40 does not have a restraint.</p> <p>47129</p> <p>Resident #112</p> <p>Review on 5/31/24 of Resident #112's progress note dated 3/18/24 revealed that Resident #42 was being discharged to home.</p> <p>Review on 3/27/24 of Resident #112's Discharge - return not anticipated MDS, with an ARD date of 3/19/24, revealed under section A210507, Identification Information: Discharge Status: 07: Inpatient Psychiatric Facility was coded indicating that Resident #42 was discharged to the psychiatric hospital.</p> <p>Interview on 5/31/24 at 9:38 a.m. with Staff C revealed that Resident #112 was discharged to home and not the psychiatric hospital. Staff C confirmed that the MDS dated [DATE], was coded incorrectly.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>47129</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that activities were provided to support residents based on the resident's choices and care plan for 1 out of 1 residents reviewed for activities in a final sample of 23 residents (Resident Identifier is #106).</p> <p>Findings include:</p> <p>Resident #106</p> <p>Observation on 5/29/24 at 9:48 a.m. in Resident #106's room revealed that Resident #106 was awake in her wheelchair with the television off. Resident #106 was staring into the hallway.</p> <p>Interview on 5/29/24 at 11:49 a.m. with Resident #106's family member revealed that he/she was concerned of the lack of music or television when he/she comes to visit Resident #106. Resident #106's family stated that Resident #106 may not be able to participate in activities, however Resident #5 can still listen, especially to activities like live music. He/She stated that Resident #106 was a singer and loved music, especially classical.</p> <p>Observation on 5/29/24 at 1:53 p.m. of the dining room revealed that there was a musician playing music for residents.</p> <p>Observation on 5/29/24 at 1:55 p.m. in Resident #106's room revealed that Resident #106 was awake in her wheelchair watching television.</p> <p>Observation on 5/30/24 at 9:00 a.m. in Resident #106's room revealed that Resident #106 was awake in bed with the television off and no music playing.</p> <p>Interview on 5/30/24 at 12:09 p.m. with Resident #106's family revealed that when he/she arrived, Resident #106 was resting in bed. He/she stated that they noticed there was a music activity going on in the dining room yesterday and they said no one came into the room and asked if Resident #106 wanted to go. He/She stated that he/she would like Resident #106 to be asked, and the resident would decide if they felt up to going or not.</p> <p>Review on 5/30/24 of Resident #106's medical diagnoses revealed that Resident #106 had a diagnosis of advanced Parkinson's disease with Dementia.</p> <p>Review on 5/30/24 of Resident #106's Recreation Comprehensive Assessment, dated 1/19/24, and completed by Resident #106's family revealed the following:</p> <ul style="list-style-type: none"> -Very important to listen to music; -Interested in pet visits; <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Very important to do things with groups of people, likes to socialize or just be present during group activities;</p> <p>-Very important to watch or listen to television.</p> <p>Review on 5/30/24 of Resident #106's current activity care plan revealed that Resident #106 enjoyed listening to classical music, watching television, to participate in music performances, and to go outside when the weather was nice.</p> <p>Review on 5/30/24 of Resident #106's March, April, and May's activity participation record revealed no documented activity participation.</p> <p>Interview on 5/30/24 at 12:30 p.m. with Staff F (Director of Activities) confirmed the above findings. Staff F stated he/she was not sure what Resident #106 preferences because he/she did not do his/her recreation assessment. Interview further revealed that if a resident declined an activity when asked to go, it would be documented on the resident's activity participation record.</p> <p>Interview on 5/30/24 at 12:30 p.m. with Staff G (Activity Aid) revealed that Resident #106 was not asked to go to the live music activity the day prior by Staff G. Staff G stated that he/she started working at the facility in the beginning of May and was unaware of what Resident #106 liked to do for activities.</p> <p>Interview on 5/30/24 at 1:00 p.m. with Staff H (Licensed Nursing Assistant) revealed that Resident #106 liked to watch television. Interview further revealed that Resident #106 was not asked to go to group activities.</p> <p>Review on 5/30/24 of the facility's policy titled, Program Design, revision dated 4/1/18, revealed: .2. The Recreation Department will create a program environment that supports a person's wellbeing and wellness. 3. Group, individual, and independent programs are reflective of the resident's/patient's comprehensive assessments and care plans and the preferences of each resident/patient and will be adapted to ensure participation</p> <p>Review on 5/30/24 of the facility's policy titled, Resident's/Patient's Choice, revision dated 4/1/18, revealed: . 2. Residents/Patients will be invited to attend activities and will be provided the opportunity to participate in structured and individual programs. 3.1 Preferences for individuals who have dementia will be determined through communication with the resident/patient, family, friends, and caregivers. 3.2 Assistance will be provided for residents/patients who wish to participate but are not able to get to activities on their own. 4. Resident/Patients who prefer not to participate in structured activities will be offered alternatives and necessary support/resources for meaningful individual pursuit of leisure interests .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43002</p> <p>Based on observation, interview, and record review it was determined that the facility failed to maintain infection control practices in regards to cleaning equipment during wound care in 1 out of 1 observations of pressure ulcer care observed in a final sample of 23 residents (Resident Identifier is #27).</p> <p>Findings include:</p> <p>Review on 5/31/24 of Resident #27's Skin and Wound Evaluation, dated 5/28/24, revealed that Resident #27 had a Deep Tissue Pressure Injury to the right dorsum hallux of the foot, measuring 0.1 by 0.4 by 0.5 centimeters.</p> <p>Review on 5/31/24 of Resident #27's May 2024 Treatment Administration Record revealed the following treatment orders:</p> <p>Cleanse pressure injury to right foot base of great toe with [wound cleanser], pat dry. Cover with oil emulsion to wound bed only, cover with non adherent foam and .wrap with a gauze bandaged roll every 3 days with a start date of 4/26/24.</p> <p>Cleanse [NAME] injuries to right calf with wound cleanser, pat dry, skin repair cream to dry periwound, apply oil emulsion if open area exist, cover with [foam dressing] . wrap with a gauze bandaged roll every 3 days with a start date of 4/19/24.</p> <p>Observation on 5/31/24 at 1:30 p.m. of Staff B (Licensed Practical Nurse) provided wound care to Resident #27's right lower leg/foot area and revealed that there was a bandaged roll, dated 5/28/24, that wrapped the resident's right calf and foot. Staff B cut the bandaged roll with clean scissors and removed the dirty dressings, revealing three different wounds; one to the right hallux (big toe joint) area, and two areas on the lower leg/calf. It was observed that there was serosanguineous drainage to the right hallux dripping down the foot. Staff B placed the dirty scissors on the clean field, removed his/her gloves and washed their hands. Further observation of the wound care revealed that Staff B used the dirty scissors to cut an oil emulsion dressing to the wound bed size, and placed it directly to the right hallux area wound bed. Staff B then used the same scissors to cut a non border foam dressing and bandage roll to cover the oil emulsion dressing. Further observation revealed Staff B also used the same dirty scissors to cut the oil emulsion dressing to the wound bed size to the 2 wounds on the calf.</p> <p>Interview on 5/31/24 at 2:00 p.m. with Staff B confirmed that he/she did not disinfect the scissors between the dirty and the clean dressing change. Staff B stated that he/she would have cleaned the scissors if they had touched the wound bed.</p> <p>Interview on 5/31/24 at 2:30 p.m. with Staff D (Director of Nursing) confirmed that he/she would expect that the scissors would be cleaned between the dirty and clean dressing change.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 6/3/24 of the Centers for Disease Control and Prevention's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 4/12/24, retrieved on 6/3/24 from https://www.cdc.gov/infection-control/hcp/core-practices/index.html, revealed: .Adherence to infection prevention and control practices is essential to providing safe and high quality patient care across all settings where healthcare is delivered . The practices outlined in this document are intended to serve as a standard reference and reduce the need to repeatedly evaluate practices that are considered basic and accepted as standards of medical care . The core practices in this document should be implemented in all settings where healthcare is delivered. These venues include both inpatient settings (e.g., acute, long-term care) . 5f. Reprocessing of Reusable Medical Equipment References and resources . Maintain separation between clean and soiled equipment to prevent cross contamination .</p> <p>37488</p>		